REPORT TO THE
NORTH CAROLINA GENERAL ASSEMBLY

BY THE
MEDICAID INVESTIGATIONS DIVISION
OF THE
NORTH CAROLINA DEPARTMENT OF JUSTICE

State Fiscal Year July 1, 2016 through June 30, 2017

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I. INTRODUCTION

Pursuant to N.C.G.S. § 114-2.5A "each year the Medicaid Fraud Control Unit of the Department of Justice," which is the Medicaid Investigations Division (MID), "shall file a written report about its annual activities" with the General Assembly. This report covers the activities of the MID for the State Fiscal Year 2016-2017 (FY 16/17), covering the period of July 1, 2016 through June 30, 2017.

G.S. § 114-2.5A requires the report on the MID's activities during the previous state fiscal year to include specific information as follows:

(1) The number of matters reported to the MID.
(2) The number of cases investigated.
(3) The number of criminal convictions and civil settlements.
(4) The total amount of funds recovered in each case.
(5) The allocation of recovered funds in each case to (i) the federal government; (ii) the State Medical Assistance Program; (iii) the Civil Penalty and Forfeiture Fund; (iv) the N.C. Department of Justice; and (v) other victims.

Because the MID receives 75% of its funds from a Federal source, the MID is required by its Federal funding source to maintain statistics and report its activities based on the Federal fiscal year, which is October 1 through September 30. The General Assembly requires that this report present statistics based on the state fiscal year of July 1 through June 30. Pursuant to G.S. § 1-617, the General Assembly also requires a report on *qui tam* cases for the calendar year of January 1 through December 31. While these three reports overlap, the statistics presented in these three reports will vary because they each cover different time periods.

Finally, it is important to note that during the 2017 regular session of the North Carolina General Assembly, SB 378, "An Act to Align The North Carolina False Claims Act", was introduced by the Senate at the request of the Department of Justice. It was referred to the Senate Rules Committee but failed to make the crossover deadline. We feel the need to highlight this piece of legislation at the outset as its codification would allow the State to receive enhanced recoveries in cases involving Medicaid fraud. Specifically, the alignment of our existing State statute with the Federal False Claims Act would provide the State with a 10% "bump" in recoveries. This equates to the State being able to retain 43 cents of every dollar recovered instead of 33 cents, which effectively results in a 30% increase in the State's recovery. Had this law been in effect since the North Carolina False Claims Act was enacted in 2011, the State could have retained an additional $25.4 million. Given the sizable amount of this additional recovery, MID by way of the Department of Justice's legislative liaison will again be advocating for the enactment of a bill that will bring our State's False Claims Act into compliance with the Federal law.

II. OVERVIEW

The MID has worked hard to combat Medicaid provider fraud, the physical abuse of patients in Medicaid funded facilities, the misappropriation of patient funds, and fraud in the administration of the Medicaid program during its 38 year history. In that time over 605 providers have been convicted of crimes relating to Medicaid provider fraud, the physical abuse of patients in Medicaid funded facilities, the misappropriation of patient personal funds, and fraud in the administration of the Medicaid program, and the MID has recovered over $812 million in fines, restitution, interest, penalties, and costs.

The MID continues to maintain strong relationships with the North Carolina Department of Health and Human Services (NC DHHS), the state agency that administers the North Carolina Medicaid Program, and with other law enforcement and prosecutorial agencies. Throughout FY 16/17, the MID continued joint investigations of fraud and patient abuse cases with a number of law enforcement and investigatory agencies, including the United States Department of Health and Human Services Office of Inspector General (OIG), Office of Investigations District Office in Greensboro, N.C.; the Federal Bureau of Investigation (FBI); the Internal Revenue Service; the United States Department of Justice; N.C. State Bureau of Investigation; and local law enforcement agencies, along with integrity Special Investigations Units (SIUs) within private insurance companies and managed care companies. These relationships serve as a valuable resource for future case referrals.

Medicaid Fraud Control Units from other states seek advice and guidance in the areas of administration, investigation, and prosecution from the MID. The MID strives to maintain and build on this reputation and to assist other units directly and through participation with the National Association of Medicaid Fraud Control Units (NAMFCU). During FY 16/17, MID Director Charlie Hobgood served as a member of the NAMFCU Executive Committee and NAMFCU working groups. MID Criminal Chief Doug Thoren served as a member of the NAMFCU Training Committee and a working group. MID Civil Chief Eddie Kirby served as a member of the NAMFCU Global Case Committee, *Qui Tam* Subcommittee, and Training Committee. MID Civil Attorney Steve McCallister served on NAMFCU working groups. The MID continues to be actively involved in national global cases being coordinated through NAMFCU with the United States Department of Justice and other federal and state agencies. Civil Chief Eddie Kirby, Financial Investigator Camille Carrion, and Assistant Attorney Generals Steve McCallister, Stacy Race, Mike Berger, and Lareena Phillips served on NAMFCU global intake groups and teams appointed by NAMFCU's Global Case Committee.

The United States Attorney's Offices for the Eastern, Middle, and Western Districts have appointed a number of MID attorneys as Special Assistant United States Attorneys (SAUSA) to pursue criminal and civil Medicaid fraud matters. MID attorneys receive many benefits from this appointment. MID attorneys are collaborating with attorneys in the United States Attorney's Offices for the Western, Middle and Eastern Districts of North Carolina on substantial criminal and civil fraud cases against a variety of Medicaid providers.

The MID has a strong relationship with the North Carolina Division of Health Service Regulation (NC DHSR), the primary agency designated to receive patient physical abuse complaints from or involving long-term care providers in North Carolina. During FY 16-17 the MID continued to provide an extensive training program for its staff through NAMFCU courses. Classes range from multi-level fraud investigation techniques to technical skills training. The MID and Division of Medical Assistance held their yearly joint training to inform all staff of various policies of both agencies and investigative best practices to further our common mission.

The North Carolina General Assembly enacted the North Carolina False Claims Act, G.S. §§ 1-605 through 1-618, effective January 1, 2010. This act established a state *qui tam* law that has improved the MID's ability to prosecute and investigate Medicaid provider fraud and abuse. Since the North Carolina False Claims Act became effective, the MID received information from and filings by whistleblowers alleging approximately 585 cases of Medicaid fraud and abuse.

In summary, the MID's activities over the past year in both the criminal and non-criminal areas have proven productive. Our successful investigation and prosecution of a variety of Medicaid providers during FY 16/17 enhanced our reputation as an effective and professional Medicaid Fraud Control Unit that vigorously, but fairly, pursues and prosecutes fraud and abuse.

III. INFORMATION REQUIRED ON MID ACTIVIITES

1. The number of matters reported to the MID.

There were 260 referrals made to the MID during the State FY 16/17; a decrease from FY 15/16. The referrals came from varied sources. Referral sources include citizens, *qui tam* relators, the Office of Compliance and Program Integrity of the Division of Medical Assistance of the NC DHHS, Managed Care Organizations (MCO) in connection with behavioral health services, the Division of Health Service Regulation, local departments of Social Services, former employees, the National Association of Medicaid Fraud Control Units, United States Attorney's Offices, and other law enforcement agencies such as FBI, OIG, IRS, DEA, and SBI.

Of those 260 new referrals, the MID opened new case files on 121 matters. The remaining 139 were referred to another agency for review, declined for insufficiency of the evidence, or rolled into existing MID investigations. In many instances it is appropriate to refer a matter to the North Carolina Division of Medical Assistance for further review or administrative action. DMA can compare the allegation to its history of the provider and conduct billing analysis and reviews to determine whether further investigation is appropriate. DMA may then refer the matter back to the MID with the additional data and analysis. In that case, the MID can reconsider whether to open an investigation. Alternatively, DMA may decide to apply one of the administrative remedies or sanctions it has at its disposal. It is also possible that the matter could be referred to another appropriate investigatory agency for action.

A number of referrals were declined on the grounds that the referral did not sufficiently allege Medicaid provider fraud, were not substantiated by a preliminary review, or the potential for successful criminal prosecution was low. Some of the allegations pertained to Medicaid recipient fraud, but the MID's federal grant does not allow the MID to use funding to investigate Medicaid recipient fraud. Therefore, the MID refers recipient fraud allegations to the Division of Medical Assistance and the county Department of Social Services. Please note that allegations of Medicaid recipient fraud should be referred to the Recipient Services Section of the Division of Medical Assistance, 919-813-5340, or the Fraud Section of the local county Department of Social Services.

Medicaid fraud investigations are complex and labor intensive. The consequences of a fraud conviction on a provider can be severe. Therefore, the MID takes great care to ensure that allegations are substantiated before proceeding with criminal charges or civil actions.

2. The number of cases investigated.

During FY 16/17 the MID staff investigated 535 cases; a decrease from FY 15/16. Due to the length of time required to properly investigate a case, a number of these cases were referred and/or opened prior to FY 16/17. The subjects of current investigations include counselors and psychologists; physicians; dentists; psychiatrists; pharmacies; pharmaceutical manufacturers; durable medical equipment suppliers; transportation providers; social workers; healthcare billing agents; home health care providers and aides; labs; nursing facilities; hospice; mental health facilities; substance abuse treatment centers; and hospitals. The MID is also investigating caregivers accused of patient physical abuse at Medicaid funded facilities, and the theft of recipients' personal funds.

3. The number of Criminal Convictions and Civil Settlements.

a. Criminal Convictions

During FY 16/17, the MID successfully convicted 17 providers; a decrease from FY 15/16. These criminal convictions resulted in more than 622 months of incarceration and in the recovery of $3,028,288.48 in restitution, fines, courts costs, supervision fees, and community services fees. A number of the convicted defendants were connected to each other in some fashion. The various types of connections included family relationships, selling Medicaid patient information to each other, loaning their provider numbers to each other, use of the same billing company, and teaching fraud techniques to each other. While these judgments ordered the repayment of over $18 million in restitution, fines, court costs, and fees, because many of the crimes were related, many of the judgments were "joint and several." We adjusted our report of the total recoveries to reflect these joint and several judgments; therefore, we are reporting $3 million in recoveries rather than $18 million. Details of these convictions are set forth in Section IV of this report.

Of particular note was the criminal conviction of Donnie Lee Phillips who was the biller for various Medicaid behavioral health provider businesses located in and around Pitt County,

North Carolina. In the capacity of biller, Phillips was primarily responsible for submitting millions of dollars of false claims to the Medicaid Program.

The investigation revealed that from September 2013 to May 2015, Phillips submitted fraudulent claims to the Medicaid Program for Medicaid providers.

On January 4, 2016, in the United States District Court for the Eastern District of North Carolina, Donnie Phillips pled guilty to Conspiracy to Commit Health Care Fraud, in violation of Title 18, United States Code, Section 1349 and Aggravated Identity Theft and Aiding and Abetting, in violation of 18 United States Code, Sections 1028(a)(1) and (2). On December 12, 2016, he was sentenced to 108 months imprisonment to be followed by three years of supervised release, given a special assessment of $200.00, and was ordered to pay restitution in the amount of $5,722,364.09. Details of this case are set forth in Section V of this report.

b. Civil Settlements

During this period the MID obtained 15 civil settlements and recovered $2,031,715.01 in damages, interest, civil penalties, and costs; a decrease from FY 15-16. This decrease was due in part to the timing of settlements. This year's civil settlements are bookended by two significant settlements. During FY 15-16 MID settled the Wyeth case for $45.3 million in June, 2016 just one month before the beginning of FY 16-17, and during the current fiscal year MID settled the Mylan case for $21.4 in August 2017 just after the end of FY 16-17. A one month difference in either settlement would have resulted in total civil settlements for FY 16-17 being in the range of from $23.4 to $47.3 million. In addition, as described in Section VI of this report, the nature of civil actions has been changing with fewer large settlements with pharmaceutical companies and an increase in the number of smaller settlements. However, even with this change, MID continues to produce a positive return on investment. Details of these settlements are set forth in Section V of this report. Of significance was a civil settlement agreement with Perry Jeffries, DDS, a dentist who provides services in Winston-Salem, Monroe, Raleigh and Greensboro, N.C. An MID investigation found that from January 1, 2012 through December 31, 2016, Jeffries submitted claims for payment to the North Carolina Medicaid Program for pediatric dental services – specifically, full mouth debridements – that had no supporting clinical documentation, were not medically necessary, and were performed in violation of Division of Medical Assistance policy. In May 2017 a settlement agreement was reached under which Jeffries paid the State of North Carolina $185,000.00. Details of this case are set forth in Section V of this report.

4. The total amount of funds recovered in each case; Allocations.

Together, these 17 criminal convictions and 15 civil recoveries represent a total of $5,060,003.49 recovered for the State of North Carolina. Consistent with federal reporting instructions, recoveries are amounts individual and organizational defendants are ordered to pay in criminal cases and must pay in civil judgments and settlements and may not reflect actual collections. A case by case breakdown of the amounts recovered in each case and allocation of recovered funds is shown below in Table A.

Table A Funds Recovered

07/01/2016 - 06/30/2017

Name	Federal Government	NC Medicaid	Civil Penalty & Forfeiture Fund	NC DOJ Costs	Other	Total
Donnie Lee Phillips, II	3,680,151.82	1,919,592.27			122,820.00	5,722,564.09 *
Cynthia Teresa Harlan	2,027,408.40	1,072,841.46			800.00	3,101,049.86 *
Jason Adam Townsend	1,771,773.06	937,567.19			100.00	2,709,440.25 *
Isaac Augustus Blount, III	85,732.00	46,183.68			1,645,988.00	1,777,903.68 *
Tyree Craig Jones	1,056,455.71	559,043.51			100.00	1,615,599.22 *
Claude Bernard McRae	1,056,455.71	559,043.51			100.00	1,615,599.22 *
Thomas Lee Garner	405,210.10	217,710.89			161,660.00	784,580.99 *
Christopher Dion Jonson	405,210.10	217,710.89			150,933.00	773,853.99 *
Reginald Lee Saunders	211,512.05	109,788.34			100.00	321,400.39 *
Ebony Phillips (aka Ebony Phillips Beam)	121,845.53	64,805.10			100.00	186,750.63 *
Tiffany Donnea Kendall	79,051.62	41,227.76			745.00	121,024.38
Michelle Denise McLamb	2,625.80	1,374.20			372.50	4,372.50
Anthony Wayne Joyner, II					860.00	860.00
Keisha Renee Covington					450.00	450.00
Edith Teachey					372.50	372.50
Davon McRoy					335.00	335.00
Katrice Waters					180.00	180.00
Total Criminal Recoveries	694,108.02	370,384.46	0.00	0.00	1,963,396.00	3,028,288.48 *
Omnicare, Inc (Depakote)	224,188.85	50,642.28	48,848.69	9,946.28	18,995.94	352,622.04
Moore County Dental Care / Anna Goodrich	194,250.00	41,481.86	41,481.86	8,446.28		285,660.00
Forest Laboratories, LLC/Forest Pharmaceuticals, INC	167,828.97	37,964.54	37,143.94	7,563.02	23,086.15	273,586.62
Walgreen Co.	176,836.41	30,109.51	29,987.62	6,105.90	17,565.87	260,605.31
Perry Jeffries, D.D.S., PA	121,970.50	28,602.79	28,602.79	5,823.92		185,000.00
Greater Home Care Agency	96,885.00	48,207.17		4,907.83		150,000.00
Inpatient Consultants	81,694.43	25,928.10	20,094.01	4,602.85		132,319.39
Biocompatibles, INC.	64,612.91	10,827.43	10,489.97	2,135.89	6,331.09	94,397.29
Genzyme Corporation	59,762.52	18,292.35		1,862.29	7,837.91	87,755.07
Salix Pharmaceuticals	55,581.94	9,380.82	9,264.35	1,886.34	4,788.71	80,902.16
Omnicare, INC. (Corsi)	28,129.12	4,430.68	7,115.76	1,165.24	2,862.60	43,703.40
Accucare, INC.	27,846.00	6,649.99	6,649.99	1,354.02		42,500.00
Omnicare, INC. (Ervin)	14,893.86	2,595.60	2,571.65	523.62	1,416.73	22,001.46
Omnicare, INC. (Remeron)	7,749.37	1,412.54	1,472.11	291.14	1,286.98	12,212.14
Emeritus Corporation	5,826.24	1,190.73	1,190.72	242.44		8,450.13
Total Civil Recoveries	1,328,056.12	317,716.39	244,913.46	56,857.06	84,171.98	2,031,715.01
Total Recoveries	2,022,164.14	688,100.85	244,913.46	56,857.06	2,047,567.98	5,060,003.49

* These defendants were ordered to repay $18,736,336.70 joint and severally. The Criminal Recoveries totals have been adjusted to reflect these joint and several judgments.

IV. CRIMINAL CONVICTIONS

The MID reports all criminal convictions to the United States Department of Health and Human Services Exclusion Program which, in turn, will take administrative action to exclude these providers from future participation as providers in Medicaid and any other federally funded health care program for a period of years.

State v. Davon McRoy

Davon McRoy was a patient of Cherry Hospital, a state-operated mental health facility located in Goldsboro, North Carolina. This case was predicated upon a referral from Cherry Hospital Police Department and from the Division of Health Service Regulation.

The investigation revealed that on or about April 10, 2016, McRoy assaulted another patient of Cherry Hospital.

On August 16, 2016, McRoy pled guilty to one count of Misdemeanor Assault on a Handicapped Person in Wayne County District Court. McRoy was sentenced to 36 days in jail. The court ordered McRoy to pay $275 in attorney's fee and a $60 appointment fee.

State v. Katrice Waters

Katrice Waters was a Healthcare Tech of O'Berry Neuro-Medical Treatment Center, a Medicaid provider located in Wayne County, North Carolina. This matter was referred to the MID by Cherry Hospital Police Department.

The investigation revealed that on or about April 20, 2016, Waters "thumped once" and "hit twice" a resident on the back of the head because the resident was walking slowly down the hallway and Waters wanted the resident to get out of her way.

On September 16, 2016, Waters pled guilty to one count of Misdemeanor Simple Assault in Wayne County District Court. Waters was sentenced and granted a prayer for judgment continued upon the payment of $180.00 for court costs.

U.S. v. Reginald Lee Saunders

Reginald Lee Saunders was the owner and/or operator of Premium Human Services, Inc., a Medicaid behavioral health provider located in Kinston, North Carolina. This case arose out of an MID investigation into a large web of Medicaid behavioral health providers surrounding Terry Speller who was convicted of felonious health care fraud in 2015. This case investigated a complicated scheme with a large amount of money and monetary transactions involved in the conspiracy. It was jointly investigated with the Office of Inspector General (OIG) and the Internal Revenue Service (IRS).

The investigation revealed that from October 2013 to September 2015, Saunders provided Medicaid Identification Numbers to Terry Speller to be utilized for fraudulent billing purposes.

On June 6, 2016, in the United States District Court for the Eastern District of North Carolina (Wilmington), Reginald Lee Saunders pled guilty to Conspiracy to Commit Health Care Fraud, in violation of Title 18, United States Code, Section 1349. On September 29, 2016 Saunders was sentenced to 35 months imprisonment to be followed by three years of supervised release. He was given a special assessment of $100.00. He was ordered to pay restitution to the Medicaid Program in the amount of $321,300.39, joint and severally liable with co-conspirators, Donnie Phillips and Terry Speller.

U.S. v. Tyree Craig Jones

Tyree Jones was an operator of Esteem Family Life Center and co-owner/operator of Kings of Carolina Care 1, Inc.; both were Medicaid behavioral health providers located in Rockingham, North Carolina. This matter was referred to the MID by the Federal Bureau of Investigation (FBI).

The investigation revealed that from 2012 to August, 2013, Jones conspired in a scheme to defraud Medicaid by misusing beneficiary identifying information to create fake reimbursement claims for non-existent services. In this scheme, Jones conspired with Cynthia Harlan, Claude McRae, and others to submit false claims to Medicaid claiming services were provided when, in fact, no services were provided. Cynthia Harlan directed co-conspirators to gather Medicaid beneficiary information and submit that information to her and others. After receiving this information, Cynthia Harlan coordinated the creation of billing spreadsheets which were then used to submit the false claims to Medicaid through the various co-conspirators Medicaid-approved companies. Tyree Jones and his co-conspirators coordinated with a team of document writers who would generate false paperwork to support these false claims in the event of an audit by Medicaid on these claims. The Medicaid providers, including Tyree Jones and Claude McRae, distributed fraud proceeds to Cynthia Harlan who then paid recruiters and note writers for their role in the scheme.

Jones, Harlan, and McRae were tried as co-defendants the week of July 11, 2016 in the United States District Court for the Western District of North Carolina. Jones changed his plea mid-trial from Not Guilty to Guilty. He was sentenced on November 7, 2016 to an active term of imprisonment of 85 months, to be followed with 3 years supervised release. He was given a $100 assessment and ordered to pay restitution to the NC Fund for Medical Assistance in the amount of $1,615,499.22, jointly and severally liable with multiple co-defendants.

U.S. v. Isaac Augustus Blount, III

Isaac Augustus Blount, III was the manager/operator of Enriched Health Services, Inc., a Medicaid behavioral health provider, located in Greenville, North Carolina. This matter was

referred to the MID by the Division of Medical Assistance, Office of Compliance and Program Integrity. This case was investigated jointly with the Internal Revenue Service.

The investigation revealed that from October 2012 to September 2012, Blount billed the Medicaid program for services not rendered. It was also discovered that he, with other co-conspirators, filed fraudulent income tax returns.

On November 9, 2016, in the United States District Court for the Eastern District of North Carolina, Blount pled guilty to False Claims Against the United States in violation of 18 U.S.C. §287 and False Statements Relating to Health Care Matters in violation of 18 U.S.C. §1035(a)(2). Blount was sentenced to 27 months imprisonment to be followed by three years of supervised release. He was given a special assessment of $200.00. He was ordered to pay restitution to the Internal Revenue Service in the amount of $1,645,788.00 and to the Medicaid Program in the amount of $131,915.68.

State v. Tiffany Donnea Kendall

Tiffany Donnea Kendall was the owner of Total Miracle Kids, a North Carolina Medicaid behavioral health provider in Gastonia, North Carolina. This matter was referred to the MID by the Division of Medical Assistance, Office of Compliance and Program Integrity.

The investigation revealed that from February 2013 to February 2015, Kendall obtained Medicaid numbers by advertising therapeutic camp services and then used those numbers to bill Medicaid for services that were not provided. Kendall submitted billings for multiple family, group and individual therapy services when those services were not provided by properly licensed individuals.

On December 5, 2016, Kendall was charged in Gaston County Superior Court on two Bills of Information. In the first Bill of Information, Kendall was charged with one count of Accessing Computers to Defraud in violation of NCGS 14-454(A) and one count of Medical Assistance Provider Fraud in violation of NCGS 108A-63. She was charged with the same offenses for a different time period in the second Bill of Information.

In the first Bill of Information, the Gaston County Superior Court sentenced Kendall to a 13-25 month sentence, suspended for five years. She was ordered to pay $372.50 in court costs and $120,279.38 in restitution to the NC Fund for Medical Assistance with $45,000 of the restitution to be paid by December 7, 2016 and thereafter at least $1000/month in restitution. Kendall was also ordered to complete 50 hours of community service in the first 120 days of her probation. In the second Bill of Information, Kendall was sentenced to 13-25 months, suspended at the expiration of her previous sentence, under the same terms and conditions, with an additional $372.50 in court costs.

U.S. v. Claude Bernard McRae

Claude McRae was an operator of Esteem Family Life Center, a Medicaid provider of mental and behavioral health, located in Rockingham, North Carolina. McRae, also, co-owned/operated Kings of Carolina Care 1, Inc., a Medicaid provider of mental and behavioral health, located in Rockingham, North Carolina. This matter was referred to the MID by the Federal Bureau of Investigation (FBI).

The investigation revealed that from 2012 to August, 2013, Claude McRae conspired in a scheme to defraud Medicaid by misusing beneficiary identifying information to create fake reimbursement claims for non-existent services. In this scheme, McRae conspired with Cynthia Harlan, Tyree Jones, and others to submit false claims to Medicaid claiming services were provided when, in fact, no services were provided. Cynthia Harlan directed co-conspirators to gather Medicaid beneficiary information and submit that information to her and others. After receiving this information, Cynthia Harlan coordinated the creation of billing spreadsheets which were then used to submit the false claims to Medicaid through the various co-conspirators Medicaid-approved companies. Claude McRae and his co-conspirators coordinated with a team of document writers who would generate false paperwork to support these false claims in the event of an audit by Medicaid on these claims. The Medicaid providers, including Claude McRae and Tyree Jones, distributed fraud proceeds to Cynthia Harlan who then paid recruiters and note writers for their role in the scheme.

McRae, Harlan, and Jones were tried as co-defendants the week of July 11, 2016 in the United States District Court for the Western District of North Carolina. Although Defendant Jones changed his plea mid-trial from not-guilty to guilty, Defendants McRae and Harlan were found Guilty by Jury on July 14, 2016. McRae was sentenced on November 30, 2016. McRae was sentenced to a term of 88 months active. McRae was given a $100 assessment and ordered to pay restitution to the NC Fund for Medical Assistance in the amount of $1,615,499.22, jointly and severally liable with multiple co-defendants.

U.S. v. Cynthia Teresa Harlan

Cynthia Harlan was owner/operator of Heartland Consulting and Marketing, LLC, located in Charlotte, North Carolina. Harlan held herself out as a consultant specializing in the operation of mental health companies and Medicaid reimbursement. While investigating a large Medicaid fraud scheme, the MID opened a criminal case on Cynthia Harlan after her role in became known to investigators.

The investigation revealed that from 2012 to August 2013, Cynthia Harlan conspired with others in a scheme to defraud Medicaid by misusing beneficiary identifying information to create fake reimbursement claims for non-existent services. In this scheme, Harlan partnered with others to submit false claims to Medicaid claiming services were provided when, in fact, no services were provided. Harlan directed co-conspirators to gather Medicaid beneficiary information and give that information to her and others. After receiving this information,

Harlan coordinated the creation of billing spreadsheets which were then used to submit the false claims to Medicaid through the various co-conspirators' Medicaid-approved companies.

Harlan and her co-conspirators coordinated with a team of document writers who would generate false paperwork to support these false claims in the event of an audit by Medicaid on these claims. The Medicaid providers, including Jones and McRae, distributed fraud proceeds to Harlan who then paid recruiters and note writers for their role in the scheme.

After learning of the MID's investigation, Cynthia Harlan instructed her co-conspirators to destroy documents, emails and text messages in an effort to obstruct the investigation.

Cynthia Harlan was tried the week of July 11, 2016, with her co-defendants, Tyree Jones and Claude McRae, in the United States District Court for the Western District of North Carolina. Cynthia Harlan and Claude McRae were found Guilty by Jury on July 14, 2016; Tyree Jones changed his plea mid-trial from Not Guilty to Guilty.

On November 30, 2016, Cynthia Harlan was sentenced to 120 months for Count 1 (Conspiracy to Commit Health Care Fraud, 18 USC 1347 and 1349; 48 months for counts 2-4 and 8 (False Statements Relating to Health Care Matters/Aiding and Abetting, 18 USC 1035 and 18:2; Obstruction of a Health Care Offense Investigation, 18 USC1518), and 24 months for Counts 5-7 (Aggravated Identity Theft, Aiding and Abetting, 18 USC 1028A(a)(1) and 18:2). Each set of counts were to run concurrently with each other, yet consecutive to the previous set for a total of 192 months active. Upon release, Harlan will serve 3 years of supervised release. She was given an $800 assessment and ordered to pay $3,100,249.86 in restitution, with $3,020,911.12 payable to the NC Fund for Medical Assistance, and $79,338.74 payable to Mecklenburg County, joint and severally liable with co-conspirators.

U.S. v. Donnie Lee Phillips II

Donnie Lee Phillips was the biller for Terry Speller and Reggie Saunders and their various Medicaid behavioral health provider businesses located in and around Pitt County, North Carolina. This case arose out of an investigation into Terry Speller's many schemes to defraud the Medicaid Program. Terry Speller was convicted of felonious health care fraud in 2015, and Saunders was convicted of felonious conspiracy to commit health care fraud in 2016. This case investigated a complicated scheme with a large amount of money and monetary transactions involved in the conspiracy. It was jointly investigated with the Office of Inspector General (OIG) and the Internal Revenue Service (IRS).

The investigation revealed that from September 2013 to May 2015, Phillips submitted fraudulent claims to the Medicaid Program for Speller and Saunders.

On January 4, 2016, in the United States District Court for the Eastern District of North Carolina, Donnie Phillips pled guilty to Conspiracy to Commit Health Care Fraud, in violation of Title 18, United States Code, Section 1349 and Aggravated Identity Theft and Aiding and Abetting, in violation of 18 United States Code, Sections 1028(a)(1) and (2). On December 12, 2016, Phillips was sentenced to 108 months imprisonment to be followed by three years of

supervised release. He was given a special assessment of $200.00. He was ordered to pay total restitution in the amount of $5,722,364.09 of which $5,599,744.09 is to the Medicaid Program. The restitution is ordered to be joint and severally liable with co-conspirators, Reggie Saunders and Terry Speller.

State v. Anthony Wayne Joyner II

Anthony Wayne Joyner, II, was a healthcare tech working at Cherry Hospital, a state-operated mental health facility, located in Goldsboro, North Carolina. This case was referred to the MID by Cherry Hospital Police Department of Goldsboro, North Carolina.

The investigation revealed that on April 10, 2016, a patient was assaulted by another patient of the facility while conspiring with Healthcare Tech (HCT) Anthony Joyner II who acted as a lookout, aided in disposing of evidence of the assault, and failing to report the assault.

On January 18, 2017, Joyner pled guilty to Misdemeanor Simple Assault in Wayne County District Court. He was sentenced to thirty days in jail, suspended for eighteen months of supervised probation. Joyner was ordered to complete sixty hours of community service. Joyner was ordered to pay $810 in court costs and fees, plus a $50 fine.

State v. Michelle Denise McLamb

Michelle Denise McLamb was a home healthcare aide working for Inomancy Home Health Care, Inc., a Medicaid home healthcare provider located in Wake County, North Carolina. This case was referred to the MID by the U.S. Internal Revenue Service (IRS).

The investigation revealed that from October 2012 to December 2013, McLamb recruited Medicaid recipients for her employer and other medical providers and submitted timesheets for home healthcare services that were not rendered.

On February 8, 2017, the defendant pled guilty in Wake County Superior Court to one count of Felony Scheme to Defraud or Obtain Property by False Pretense from the Medical Assistance Program. On February 8, 2017, McLamb was sentenced to five to fifteen months in prison, suspended for thirty-six months of supervised probation. She was ordered to pay $4,000 in restitution to the N.C. Medicaid Program. McLamb was also ordered to pay court costs. She was ordered to complete twenty-five hours of community service per week unless gainfully employed or in school. After eighteen months of supervised probation, McLamb can be transferred to unsupervised probation if she is in full compliance with all terms of probation and has full paid all costs and restitution.

U.S. v. Ebony Phillips (aka Ebony Phillips Beam)

Ebony Phillips Beam was co-owner/operator of Unlimited Possibilities, Inc., a Medicaid behavioral health provider located in Shelby, North Carolina. This case arose out of an investigation into another Medicaid provider.

The investigation revealed that from November 2011 to September 2012, Beam and co-conspirators committed Medicaid Fraud by billing for services as if they were provided by qualified Medicaid providers, when in fact, such services were not provided.

On October 14, 2016, Beam pled guilty to one count of Conspiracy to Commit Healthcare Fraud in violation of 18 U.S.C. §§ 1347 and 1349. On March 1, 2017, the United States District Court for the Western District of North Carolina sentenced Beam to 9 months in the Bureau of Prisons, to be followed by 3 months electronic house arrest. She was placed on 2 years supervised release after her sentence is complete. She is to surrender to U.S. Immigration upon release from prison. Beam was also ordered to pay a $100 assessment and restitution to the NC Fund for Medical Assistance in the amount of $186,650.53, joint and severally liable with her co-conspirators.

U.S. v. Christopher Dion Johnson

Christopher Dion Johnson was an owner of Essence of Care, LLC, a Medicaid behavioral health provider located in Greensboro, North Carolina. Essence of Care was authorized to provide multiple types of behavioral health services including alcohol and substance abuse treatment. This case was referred to the MID by the Greensboro Police Department.

The investigation revealed that Johnson committed Medicaid fraud and tax evasion. The Medicaid fraud occurred from on or about Apri1 1, 2009 through on or about December 1, 2012.

On July 27, 2016, in the United States District Court for Middle District of North Carolina, Johnson pled guilty to one count of conspiracy to commit health care fraud in violation of 18 U.S.C. 1349 and one count of tax evasion in violation of 26 U.S.C. 7201. After his plea, Johnson provided substantial assistance to the Government. On March 2, 2017, Johnson was sentenced to 14 months of imprisonment, 4 months of home detention, and 3 years of supervised release to be served after the active sentence with one of the conditions for supervised release being that Johnson "shall not engage in any occupation, business, or profession related to the health care field as associated with benefits, claims, payment or billing and/or involving the Medicaid Program." Johnson was ordered to pay a $100 assessment for each count; restitution of $622,920.99 to the North Carolina Fund for Medical Assistance, jointly and severally liable with Thomas Garner; and restitution of $150,733.00 to the Internal Revenue Service.

State v. Keisha Renee Covington

Keisha Covington was owner of A New Beginning Adult and Youth Services located in Rockingham, North Carolina. A New Beginning provided child and adolescent day treatment, community support, diagnostic assessments, CAP/innovations services, personal care services, respite and other Medicaid eligible services. This case was referred to the MID from the North Carolina Division of Medical Assistance (DMA), Office of Compliance and Program Integrity.

The investigation revealed that on March 26, 2012, Ms. Covington submitted an application to be a Medicaid provider through the Sandhills Managed Care Organization

network. Ms. Covington falsely represented her company, stating she had necessary credentialing qualifications to be a provider. A true application would not have allowed her to become a provider. Ms. Covington's false statement in her application violated N.C.G.S. 108A-63(c).

On April 10, 2017, Covington pled guilty to the Class 1 misdemeanor of Attempted Medical Assistance Fraud by Provider. Moore County District Court sentenced Covington to 100 hours of community service to be completed within 150 days. Ms. Covington also received a 45 day suspended sentence with 18 months of supervised probation.

State v. Edith Teachey

Edith Teachey was a healthcare tech and certified nurse aide working at Cherry Hospital, a Medicaid mental health facility located in Goldsboro, North Carolina. This case was predicated upon a referral received from Cherry Hospital Police.

The investigation revealed that on February 21, 2016, Teachey grabbed a mentally handicapped resident and patient of Cherry Hospital around the neck and choked the patient, causing injuries of large scratch marks on the patient's neck. Surveillance video captured the incident and photographs of the injuries were taken by the police department.

On May 17, 2017, Teachey was found guilty by a jury of misdemeanor Assault on a Handicapped Person, in Wayne County Superior Court. That same day, Teachey was sentenced to ten days in the jail. She was also ordered to pay $372.50 for court costs.

U.S. v. Thomas Lee Garner

Thomas Lee Garner was a manager of Essence of Care, LLC, a Medicaid behavioral health provider located in Greensboro, North Carolina. Essence of Care was authorized to provide multiple types of behavioral health services including alcohol and substance abuse treatment. This matter was referred to the MID by the Greensboro Police Department.

The investigation revealed that from April of 2009 to December 1, 2012, Garner and co-conspirator, Christopher Dion Johnson, paid recruiters to obtain Medicaid identification numbers and billed for services not rendered.

On November 18, 2016, in the United States District Court for Middle District of North Carolina, Garner pled guilty to one count of conspiracy to commit health care fraud in violation of 18 U.S.C. 1349 and one count of tax evasion in violation of 26 U.S.C. 7201. After his plea, Garner provided substantial assistance to the Government. On June 8, 2017, Garner was sentenced to 26 months incarceration; 3 years of supervised release to be served after the active sentence with one of the conditions for supervised release being that Garner "shall not engage in any occupation, business, or profession related to the health care field as associated with benefits, claims, payment, or billing and/or involving the Medicaid Program"; $100 assessment for each count ($200 total); restitution of $622,920.99 to the North Carolina Fund

for Medical Assistance (jointly and severally liable with Christopher Johnson); and restitution of $161,460.00 to the Internal Revenue Service.

U.S. v. Jason Adam Townsend

Jason Townsend was a co-owner of TownHall Enterprises, LLC, located in Raeford, North Carolina. TownHall Enterprises operated as a third party billing provider for mental health companies and other health providers. This matter was referred to the MID by the FBI after it was determined Townsend was the biller in a large scheme involving Cynthia Harlan and many others.

The investigation revealed that Townsend's submissions of false claims resulted in millions of dollars of false and fraudulent payments to providers who, in turn, compensated Cynthia Harlan and Townsend for those claims. Harlan was convicted of felonies in November 2016.

Townsend was initially charged in a ten-count Bill of Indictment in the Western District of North Carolina. Townsend was later named in a one-count Bill of Information filed in the Western District of North Carolina on February 6, 2017. The Bill of Information charged Townsend with Conspiracy to Defraud the United States in violation of 18 U.S.C. § 371. On February 8, 2017, Townsend entered a plea of guilty to the Bill of Information. The plea agreement in the case stipulated that the government would dismiss the ten charges in the Bill of Indictment. The United States District Court for the Western District of North Carolina sentenced Townsend on June 1, 2017 to 42 months in the U.S. Bureau of Prisons. Upon his release from imprisonment, Townsend will be on supervised release for a term of two years. He was ordered to pay a $100 assessment and was ordered to pay restitution totaling $2,709,340.25. The restitution is to be divided as follows: to the NC Fund for Medical Assistance in the amount of $2,630,001.51, and to Mecklenburg County (former LME/MCO of Mecklink) in the amount of $79,338.74. The restitution is to be paid joint and severally with his many co-defendants.

V. CIVIL RECOVERIES

OMNICARE, INC. (DEPAKOTE)

Omnicare, Inc. is a Delaware corporation with its principal place of business in Cincinnati, Ohio. Omnicare provides pharmaceuticals and related pharmacy services to long-term care facilities as well as chronic care facilities and other settings. This matter was referred to the MID by the *qui tam* plaintiff.

It was alleged that from January 1, 2001 through December 31, 2008, Omnicare received illegal remuneration from Abbott Laboratories to induce Omnicare to promote and/or purchase Abbott's prescription drug Depakote.

On October 14, 2016, in conjunction with a national settlement, a settlement agreement was executed between Omnicare and the State of North Carolina in settlement of these

allegations. Under the terms of North Carolina's settlement, the State of North Carolina recovered $352,622.04. Of that amount, the federal government received $224,188.85 to satisfy North Carolina's obligation to return the federal portion of Medicaid recoveries to the federal government. The North Carolina State share of the settlement was $128,433.19. Of this amount, $50,642.28 was paid to the North Carolina Medicaid Program as restitution and interest, $48,848.69 was paid to the Civil Penalty Forfeiture Fund for the support of public schools, $18,995.94 was paid to the qui tam plaintiff, and $9,946.28 was paid to the North Carolina Department of Justice for costs of collection and investigation.

MOORE COUNTY DENTAL CARE/ANNA GOODRICH

Moore County Dental Care is a dental practice owned by Anna Goodrich, a licensed dentist in North Carolina. This matter was referred to the MID by the U.S. Attorney's Office for the Middle District of North Carolina.

It was alleged that from September 1, 2008 through April 30, 2010, Moore Dental submitted claims to Medicaid for certain dental appliances (dentures, partials, etc.) that were never delivered to patients. It was also alleged that comprehensive dental examinations, allegedly provided by Goodrich, were completed when she was out of the country, state, or town. This matter was worked jointly with the United States Attorney's Office for the Middle District of North Carolina. The settlement was negotiated by the United States Attorney's Office for the Middle District of North Carolina and the Medicaid Investigations Division.

On September 27, 2016, a settlement agreement was executed between Moore County Dental Care/Anna Goodrich and the United States and the State of North Carolina in settlement of these allegations. Under the terms of North Carolina's settlement, the State of North Carolina recovered $285,660.00. Of that amount, the federal government received $194,250.00 to satisfy North Carolina's obligation to return the federal portion of Medicaid recoveries to the federal government. The North Carolina State share of the settlement was $91,410.00. Of this amount, $41,481.86 was paid to the North Carolina Medicaid Program as restitution, $41,481.86 was paid to the Civil Penalty Forfeiture Fund for the support of public schools, and $8,446.28 was paid to the North Carolina Department of Justice for costs of collection and investigation.

FOREST LABORATORIES, LLC/FOREST PHARMACEUTICALS, INC.

Forest Laboratories, LLC is a Delaware limited liability company with its principal place of business in Parsippany, New Jersey and is the parent of subsidiary Forest Pharmaceuticals, Inc. Forest Labs/Forest Pharmaceuticals engaged in limited manufacturing of prescription pharmaceutical products in the United States. This matter was referred to the MID by the *qui tam* plaintiff.

It was alleged that from January 1, 2008 through December 31, 2011, Forest Labs/Forest Pharmaceuticals paid kickbacks to physicians in order to induce them to prescribe Bystolic, Savella, and Namenda.

On February 15, 2017, in conjunction with a national settlement, a settlement agreement was executed between Forest Labs/Forest Pharmaceuticals and the State of North Carolina in settlement of these allegations. Under the terms of North Carolina's settlement, the State of North Carolina recovered $273,586.62. Of that amount, the federal government received $167,828.97 to satisfy North Carolina's obligation to return the federal portion of Medicaid recoveries to the federal government. The North Carolina State share of the settlement was $105,757.65. Of this amount, $37,964.54 was paid to the North Carolina Medicaid Program as restitution and interest, $37,143.94 was paid to the Civil Penalty Forfeiture Fund for the support of public schools, $23,086.15 was paid to the qui tam plaintiff, and $7,563.02 was paid to the North Carolina Department of Justice for costs of collection and investigation.

WALGREEN CO.

Walgreen Co. is a Delaware corporation with its principal place of business in Deerfield, New Jersey. This matter was referred to the MID by the *qui tam* plaintiff.

It was alleged that from January 1, 2011 through December 31, 2015, Walgreens knowingly solicited and allowed individuals receiving benefits from the state Medicaid program to enroll in its Prescription Savings Club program in order to induce such individuals to self-refer prescriptions to Walgreens' pharmacies.

On February 23, 2017, in conjunction with a national settlement, a settlement agreement was executed between Walgreens and the State of North Carolina in settlement of these allegations. Under the terms of North Carolina's settlement, the State of North Carolina recovered $260,605.31. Of that amount, the federal government received $176,836.41 to satisfy North Carolina's obligation to return the federal portion of Medicaid recoveries to the federal government. The North Carolina State share of the settlement was $83,768.90. Of this amount, $30,109.51 was paid to the North Carolina Medicaid Program as restitution and interest, $29,987.62 was paid to the Civil Penalty Forfeiture Fund for the support of public schools, $17,565.87 was paid to the qui tam plaintiff, and $6,105.90 was paid to the North Carolina Department of Justice for costs of collection and investigation.

PERRY JEFFRIES, D.D.S., PA

Perry Jeffries, D.D.S., PA is a North Carolina Medicaid provider that provides pediatric dental services in Winston Salem, Monroe, Raleigh, and Greensboro, N.C. This matter was discovered during the course of an investigation of another MID case.

It was alleged that from January 1, 2012 through December 31, 2016, Jeffries submitted claims to the Medicaid program for Full Mouth Debridements that were not medically necessary.

On May 17, 2017, a settlement agreement was executed between Perry Jeffries and the State of North Carolina in settlement of these allegations. Under the terms of North Carolina's

settlement, the State of North Carolina recovered $185,000.00. Of that amount, the federal government received $121,970.50 to satisfy North Carolina's obligation to return the federal portion of Medicaid recoveries to the federal government. The North Carolina State share of the settlement was $63,029.50. Of this amount, $28,602.79 was paid to the North Carolina Medicaid Program as restitution, $28,602.79 was paid to the Civil Penalty Forfeiture Fund for the support of public schools, and $5,823.92 was paid to the North Carolina Department of Justice for costs of collection and investigation.

GREATER HOME CARE AGENCY

Greater Home Care Agency provides personal care services in Fayetteville, North Carolina. This matter was referred to MID by the Division of Medical Assistance, Office of Compliance and Program Integrity.

It was alleged that from January 1, 2008 through May 1, 2010, Greater Home Care submitted claims for services that were not rendered to twenty-two different minor recipients and submitted claims for the delivery of personal care services for a recipient in violation of Medicaid policy, which prohibits the provision of services by an immediate family member of the recipient.

On December 21, 2016, a settlement agreement was executed between Greater Home Care and the State of North Carolina in settlement of these allegations. Under the terms of North Carolina's settlement, the State of North Carolina recovered $150,000.00. Of that amount, the federal government received $96,885.00 to satisfy North Carolina's obligation to return the federal portion of Medicaid recoveries to the federal government. The North Carolina State share of the settlement was $53,115.00. Of this amount, $48,207.17 was paid to the North Carolina Medicaid Program as restitution and $4,907.83 was paid to the North Carolina Department of Justice for costs of investigation.

INPATIENT CONSULTANTS (IPC)

Inpatient Consultants was a Delaware corporation with its principal place of business in North Hollywood, California. Inpatient Consultants provided hospitalist staffing and related services to hospitals and various long-term care facilities nationwide. This matter was referred to the MID by the National Association of Medicaid Fraud Control Units.

It was alleged that from January 1, 2003 through June 16, 2014, Inpatient Consultants billed the Medicaid program for higher and more expensive levels of medical service than were actually performed.

On April 20, 2017, in conjunction with a national settlement, a settlement agreement was executed between Inpatient Consultants and the State of North Carolina in settlement of these allegations. Under the terms of North Carolina's settlement, the State of North Carolina recovered $132,319.39. Of that amount, the federal government received $81,694.43 to satisfy North Carolina's obligation to return the federal portion of Medicaid recoveries to the federal

government. The North Carolina State share of the settlement was $50,624.96. Of this amount, $25,928.10 was paid to the North Carolina Medicaid Program as restitution and interest, $20,094.01 was paid to the Civil Penalty Forfeiture Fund for the support of public schools, and $4,602.85 was paid to the North Carolina Department of Justice for costs of collection and investigation.

BIOCOMPATIBLES, INC.

Biocompatibles, Inc. is a Delaware corporation with its principal place of business in Conshohocken, Pennsylvania. Biocompatibles developed and manufactured a medical device sold in the United States under the trade name LC Bead. This matter was referred to the MID by the *qui tam* plaintiff.

It was alleged that from May 1, 2006 through December 31, 2011, Biocompatibles off-label marketed its LC Bead medical device.

On January 10, 2017, in conjunction with a national settlement, a settlement agreement was executed between Biocompatibles and the State of North Carolina in settlement of these allegations. Under the terms of North Carolina's settlement, the State of North Carolina recovered $94,397.29. Of that amount, the federal government received $64,612.91 to satisfy North Carolina's obligation to return the federal portion of Medicaid recoveries to the federal government. The North Carolina State share of the settlement was $29,784.38. Of this amount, $10,827.43 was paid to the North Carolina Medicaid Program as restitution and interest, $10,489.97 was paid to the Civil Penalty Forfeiture Fund for the support of public schools, $6,331.09 was paid to the qui tam plaintiff, and $2,135.89 was paid to the North Carolina Department of Justice for costs of collection and investigation.

GENZYME CORPORATION

Genzyme is a Massachusetts corporation with its headquarters in Cambridge, Massachusetts. This matter was referred to the MID by the *qui tam* plaintiff.

It was alleged that from October 1, 2007 through December 5, 2016, Genzyme improperly underpaid its Medicaid Rebate obligations by falsely under-reporting Average Manufacturer Price to the Center for Medicare and Medicaid Services.

Under the terms of North Carolina's settlement, the State of North Carolina recovered $87,755.07. Of that amount, the federal government received $59,762.52 to satisfy North Carolina's obligation to return the federal portion of Medicaid recoveries to the federal government. The North Carolina State share of the settlement was $27,992.55. Of this amount, $18,292.35 was paid to the North Carolina Medicaid Program as restitution, $7,837.91 was paid to the qui tam plaintiff, and $1,862.29 was paid to the North Carolina Department of Justice for costs of investigation.

SALIX PHARMACEUTICALS

Salix is a Delaware corporation with its principal place of business in Raleigh, North Carolina. Salix distributed, marketed, and/or sold pharmaceutical products in the United States, including Xifaxan, Apriso, Relistor, MoviPrep, and OsmoPrep. This matter was referred to the MID by the *qui tam* plaintiff.

It was alleged that from January 1, 2009 through December 31, 2013, Salix knowingly offered and paid remuneration to physicians and other healthcare providers to induce them to recommend, promote and prescribe Xifaxan, Apriso, Relistor, MoviPrep, and OsmoPrep.

On August 8, 2016, in conjunction with a national settlement, a settlement agreement was executed between Salix and the State of North Carolina in settlement of these allegations. Under the terms of North Carolina's settlement, the State of North Carolina recovered $80,902.16. Of that amount, the federal government received $55,581.94 to satisfy North Carolina's obligation to return the federal portion of Medicaid recoveries to the federal government. The North Carolina State share of the settlement was $25,320.22. Of this amount, $9,380.82 was paid to the North Carolina Medicaid Program as restitution and interest, $9,264.35 was paid to the Civil Penalty Forfeiture Fund for the support of public schools, $4,788.71 was paid to the qui tam plaintiff, and $1,886.34 was paid to the North Carolina Department of Justice for costs of collection and investigation.

OMNICARE, INC. (CORSI)

Omnicare, Inc. is a Delaware corporation with its principal place of business in Cincinnati, Ohio. Omnicare provides pharmaceuticals and related pharmacy services to long-term care facilities as well as chronic care facilities and other settings. This matter was referred to the MID by *qui tam* plaintiff Corsi.

It was alleged that from January 1, 2008 through December 31, 2014, Omnicare billed for drugs with different NDC's than those actually dispensed.

On May 10, 2017, in conjunction with a national settlement, a settlement agreement was executed between Omnicare and the State of North Carolina in settlement of these allegations. Under the terms of North Carolina's settlement, the State of North Carolina recovered $43,703.40. Of that amount, the federal government received $28,129.12 to satisfy North Carolina's obligation to return the federal portion of Medicaid recoveries to the federal government. The North Carolina State share of the settlement was $15,574.28. Of this amount, $4,430.68 was paid to the North Carolina Medicaid Program as restitution and interest, $7,115.76 was paid to the Civil Penalty Forfeiture Fund for the support of public schools, $2,862.60 was paid to the qui tam plaintiff, and $1,165.24 was paid to the North Carolina Department of Justice for costs of collection and investigation.

ACCUCARE, INC.

Accucare, Inc. is a North Carolina Medicaid Provider that supplies Durable Medical Equipment in and around Asheville, North Carolina. This matter was referred to MID by the Division of Medical Assistance, Office of Compliance and Program Integrity.

It was alleged that from January 3, 2012 through January 8, 2014, Accucare submitted claims for Durable Medical Equipment products that were not properly supported on a Certificate of Medical Necessity ("CMN") and added medical products to existing CMNs after the physician certified the medical necessity of the products previously listed.

On May 17, 2017, a settlement agreement was executed between Accucare and the State of North Carolina in settlement of these allegations. Under the terms of North Carolina's settlement, the State of North Carolina recovered $42,500.00. Of that amount, the federal government received $27,846.00 to satisfy North Carolina's obligation to return the federal portion of Medicaid recoveries to the federal government. The North Carolina State share of the settlement was $14,654.00. Of this amount, $6,649.99 was paid to the North Carolina Medicaid Program as restitution, $6,649.99 was paid to the Civil Penalty Forfeiture Fund for the support of public schools, and $1,354.02 was paid to the North Carolina Department of Justice for costs of collection and investigation.

OMNICARE, INC. (ERVIN)

Omnicare, Inc. is a Delaware corporation with its principal place of business in Cincinnati, Ohio. Omnicare provides pharmaceuticals and related pharmacy services to long-term care facilities as well as chronic care facilities and other settings. This matter was referred to the MID by *qui tam* plaintiff Ervin.

It was alleged that from January 1, 2006 through September 1, 2014, Omnicare manually altered the NDC field on rejected Medicaid pharmacy claims, thereby rendering the re-submitted claims inconsistent with the underlying prescriptions.

On October 13, 2016, in conjunction with a national settlement, a settlement agreement was executed between Omnicare and the State of North Carolina in settlement of these allegations. Under the terms of North Carolina's settlement, the State of North Carolina recovered $22,001.46. Of that amount, the federal government received $14,893.86 to satisfy North Carolina's obligation to return the federal portion of Medicaid recoveries to the federal government. The North Carolina State share of the settlement was $7,107.60. Of this amount, $2,595.60 was paid to the North Carolina Medicaid Program as restitution and interest, $2,571.65 was paid to the Civil Penalty Forfeiture Fund for the support of public schools, $1,416.73 was paid to the qui tam plaintiff, and $523.62 was paid to the North Carolina Department of Justice for costs of collection and investigation.

OMNICARE, INC. (REMERON)

Omnicare, Inc. is a Delaware corporation with its principal place of business in Cincinnati, Ohio. Omnicare provides pharmaceuticals and related pharmacy services to long-term care facilities as well as chronic care facilities and other settings. This matter was referred to the MID by the *qui tam* plaintiff.

It was alleged that from October 1, 2001 through December 31, 2004, Omnicare received kickbacks from Organon for recommending the prescription of Remeron to Medicaid patients.

On May 10, 2017, in conjunction with a national settlement, a settlement agreement was executed between Omnicare and the State of North Carolina in settlement of these allegations. Under the terms of North Carolina's settlement, the State of North Carolina recovered $12,212.14. Of that amount, the federal government received $7,749.37 to satisfy North Carolina's obligation to return the federal portion of Medicaid recoveries to the federal government. The North Carolina State share of the settlement was $4,462.77. Of this amount, $1,412.54 was paid to the North Carolina Medicaid Program as restitution and interest, $1,472.11 was paid to the Civil Penalty Forfeiture Fund for the support of public schools, $1,286.98 was paid to the qui tam plaintiff, and $291.14 was paid to the North Carolina Department of Justice for costs of collection and investigation.

EMERITUS CORPORATION

Emeritus is a Washington corporation with its principal place of business in North Seattle, Washington. Emeritus owns and operates assisted living and skilled nursing facilities throughout the United States. This matter was referred to the MID by the National Association of Medicaid Fraud Control Units.

It was alleged that from May 12, 2008 through May 12, 2014, Emeritus failed to return certain overpayments that it received from the state Medicaid programs on fee-for-service assisted living claims.

On November 17, 2016, in conjunction with a national settlement, a settlement agreement was executed between Emeritus and the State of North Carolina in settlement of these allegations. Under the terms of North Carolina's settlement, the State of North Carolina recovered $8,450.13. Of that amount, the federal government received $5,826.24 to satisfy North Carolina's obligation to return the federal portion of Medicaid recoveries to the federal government. The North Carolina State share of the settlement was $2,623.89. Of this amount, $1,190.73 was paid to the North Carolina Medicaid Program as restitution and interest, $1,190.72 was paid to the Civil Penalty Forfeiture Fund for the support of public schools, and $242.44 was paid to the North Carolina Department of Justice for costs of collection and investigation.

VI. PROSPECTUS

Each year the MID has consistently endeavored to achieve a high standard of excellence in our efforts to effectively and efficiently combat fraud and abuse within the Medicaid Program. We continue to be optimistic about the overall progress of our efforts to combat fraud and abuse in the Medicaid Program. Our optimism is based on a number of factors.

- ✓ MID criminal and civil attorneys and investigators are working jointly with other DOJ Sections and the SBI/DECU, providing research and investigation, to combat the opioid epidemic.
- ✓ We continue to have a reliable exchange with our Medicaid single-state agency, DMA, especially the DMA/Office of Compliance and Program Integrity, as well as other state and federal investigative and prosecutorial agencies. These relationships have played an important role in the MID's success to date and should significantly contribute to the MID's accomplishments in future fiscal years.
- ✓ MID investigators continue to uncover and obtain evidence showing complex fraud schemes. MID criminal enforcement attorneys continue to make a significant impact by prosecuting felony cases resulting in active time. MID civil enforcement attorneys continue to be actively involved in numerous state cases and national global/multi-state civil cases which have potential for successful conclusions and the recovery of funds for the state in future fiscal years.
- ✓ Each of the Managed Care Organizations (MCOs) managing North Carolina's Behavioral Health Managed Care 1915(b)(c) Waiver program has appointed a Compliance Officer and Committee whose duties include implementing an effective system for identifying and reporting fraud. DMA and MID have provided training to the MCOs on identifying and reporting fraud. DMA and MID have been meeting on a quarterly basis with the MCO compliance staff. MCO compliance staff has shown serious interest in the training and meetings and an understanding of the importance of reporting fraud. MCO compliance staff members have become an important source of fraud referrals in connection with the Medicaid behavioral health program, and we are optimistic that this collaboration will increase.
- ✓ MID continues to have a robust and creative training program that will increase the skill and abilities of MID staff and increase proficiency in investigating and prosecuting fraud and abuse. The Office of Inspector General has highlighted our partnering with another state agency to create a Financial Investigator Academy as a best practice.
- ✓ Utilization of the latest technology for data analytics allows attorneys and investigators to obtain necessary information expeditiously and efficiently in complex fraud investigations. MID software has significantly improved the speed with which MID investigators can import and analyze bank records.
- ✓ The Affordable Care Act (ACA), Title 42 C.F.R. 455.23, requires DMA to suspend payments to any Medicaid provider where there is a credible allegation of fraud unless the MFCU requests that suspension not be imposed if suspension would jeopardize an

ongoing investigation. Consistent with procedures established by MFCUs nationwide, the MID and DMA have created a process whereby when DMA refers a provider to the MID, the MID may not object to the suspension of the provider or MID may request that DMA not suspend the provider consistent with the regulation. As a result of this regulation, DMA has been able to suspend Medicaid providers when appropriate in order to prevent further losses of taxpayer money to fraud, and in appropriate cases MID has been able to request that suspension not be imposed if suspension might compromise or jeopardize an investigation. For a full description of the regulation, please see 42 C.F.R. 455.23.

- ✓ With the implementation of the Medicare Part D prescription drug coverage, states began helping pay for Part D through a phased down State contribution mechanism popularly known as "clawback." It is estimated that in 2017 the North Carolina Medicaid Program will pay over $306.6 million to the federal government in clawback payments. During this time the federal government received millions for fraud and overpayment cases involving Part D drugs. Despite the states' contributions to the Medicare Part D program, states have not received a single dollar of those recoveries. MID worked with Attorney General Josh Stein, the National Association of Medicaid Fraud, and the National Association of Attorney Generals to lead a bi-partisan effort to address this inequity. On May 17, 2017 Attorney General Josh Stein co-sponsored a letter signed by the Attorney Generals of 49 states and two territories and sent the letter to the U.S. Senate Finance Committee asking them to introduce legislation that would allow the federal government to return prescription drug settlement monies to the states. If successful, this effort should result in the return of considerable funds to North Carolina.

Our optimism must be tempered by identified challenges for the MID as follows: (1) the lingering effect of the loss of reliable data in 2013 and 2014; (2) a change in the nature of civil actions and the resulting decrease in recoveries with a corresponding decrease in cost of collections available to fund operations; (3) a reduction in MID's budget and resulting limitation on our abilities to investigate and prosecute fraud; and (4) the need to upgrade and enhance our case and document management systems which cannot be accomplished with the current amount of state 25% funding.

In our 2014 and 2015 Annual Reports we described the history and the challenges of not having access to reliable data. The MID relies on the Medicaid data repository and access systems to efficiently and effectively prosecute fraud and recover monies. We noted that in 2013 the MID lost access to current data that was sufficiently reliable to be admissible in court which required MID to develop work around plans to obtain reliable data on a case by case basis. We were pleased to report that as of September 23, 2015, the issue of access to reliable data was substantially resolved for the MID. While the loss of data during 2013 and 2014 continues to have an impact on current conviction and recovery levels due to the decrease in case referrals before the resolution of this issue, as we go forward access to reliable data will allow us to continue the successful prosecution and recovery of funds lost due to fraud.

The nature of civil actions is changing. In past years the MID obtained significant civil recoveries in civil False Claims Act cases against pharmaceutical manufacturers that were alleged to have engaged in improper off-label marketing and pricing schemes. However, there has been a shift in the landscape of national civil Medicaid fraud cases. The MID has increased the number of state and regional settlements, but the number and size of national settlements has decreased. In prior years the MID settlements included multi-million dollar recoveries from large pharmaceutical manufacturers that allegedly engaged in off-label marketing of drugs with substantial utilization of those drugs in North Carolina. Most of these recoveries resulted from joint actions taken by the federal government, North Carolina, and other participating states. These significant recoveries by the federal government and states have substantially and uniformly decreased due to a number of market factors including the following:

- As a positive change, prior year cases have changed the behavior of the industry. Enforcement efforts may have decreased the off-label marketing business practices of pharmaceutical companies which we count as a success consistent with our ultimate goal of eliminating fraud in the Medicaid program. The decrease may also be explained in part by the federally mandated higher transparency that now exists in the financial relationships between pharmaceutical companies and the physicians with whom they do business. In addition, as a condition of these settlements, pharmaceutical companies were required to adopt corporate integrity agreements that were designed to prevent future abusive practices. Other corporations have adopted voluntary compliance programs, promoted by OIG, which may have further reduced the incidence of fraud allegations.
- A significant shift in prescription drug spending from Medicaid to Medicare occurred in 2006 with the inception of Medicare Part D. The period of covered conduct in False Claims Act cases can go back 10 years. We have been transitioning into a period of time in which a larger portion of the covered conduct in prescription drug False Claims Act settlements will have occurred after the inception of Medicare Part D. Therefore, a larger portion of the payments being recovered in future settlements will be allocated to repay Medicare Part D as opposed to Medicaid.
- North Carolina and other states are transitioning their Medicaid programs to managed care. State Medicaid Agencies and MFCUs are developing policies to allocate, and strategies to recover, Medicaid damages in the context of managed care. This is an ongoing process. How recoveries occur in a managed care context is still under review.
- Named defendants in pending False Claims Act actions have shifted from being primarily national pharmaceutical companies to being state and regional hospitals, nursing homes, dental, and similar providers. We are bringing more actions and settlements than ever, but more of these involve state and regional providers. Pursuing actions against this type of defendant is important, but can be resource-intensive, may raise ability-to-pay issues, may result in smaller per-settlement monetary recoveries, and may result in the need to collect more payments over time. Actions against larger companies are typically settled with one lump-sum payment made at the time of settlement.

Actions against smaller providers with a more limited ability to pay may need to be settled with payments over time with interest, resulting in a delay in receipt of full costs.

These trends could affect the current MID operations model. By way of background, the MID is funded 75% by a federal grant and 25% by state matching funds. These trends warrant careful monitoring to ensure a stable source of the State's required matching funds. We want to emphasize that the MID civil and criminal operations continue to recover funds resulting in a positive return on investment for North Carolina. In state fiscal year 2016, the MID obtained $3,029,288.48 in criminal judgments and $2,031,715.01 in civil recoveries for a total of $5,060,003.49. These MID civil and criminal operations resulted in a positive return on investment in SFY 2016 for every state dollar invested in MID. In addition, MID operations saved state funds by deterring potential fraudsters.

A further challenge to MID operations was the General Assembly's July 2017 reduction in the budget of the Attorney General's Office by $10 million. Of note, in order to comply with the budget reduction, MID had to end the contracts of two highly experienced contract Financial Investigators. It is also important to note that the decrease in state funding will also result in a decrease in the corresponding 75% federal funding.

One of our most pressing challenges is the need to modernize our current case and document management systems. The Office of Inspector General, our federal oversight agency, sent an audit report to MID recommending that MID replace its current case and document management systems. We concur with OIG's audit finding. Unfortunately, as a result of the above described July 2017 budget reduction, MID must postpone the purchase of new case and document management systems. While MID's federal grant would pay for 75% of the cost of a new case and document management system used by MID, these federal funds would not be approved unless state funds are made available to pay for 25% of the systems used by MID. In the meantime, the MID has researched potential enhancements of our system and will continue to work with the Department of Justice IT and Fiscal staffs to develop a business plan for future enhancements if funding becomes available.

In conclusion, we remain optimistic as to the long term success of the MID. We are committed to fight fraud and abuse in the Medicaid Program as efficiently and effectively as possible and pledge our best efforts toward the accomplishment of that goal.